

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03128

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester C o.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		c. LENGTH OF STAY IN Is <b>41 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md. 13</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Md. Hospital</b>				d. STREET ADDRESS <b>Peachblossom Ave.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles D. Aaron</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26,</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1914</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Fishing Creek, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dolby Aaron</b>				14. MOTHER'S MAIDEN NAME <b>Susie Simmons</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Mrs Ormand Kirwan Peachblossom Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary fat embolism.</b> 936.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Fracture of humerus.</b> (c) <b>13 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Was found lying in ditch.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Highway</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7</b> p.m. <b>3-22 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 29, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service</b>				24a. REC'D BY REGISTRAR <b>APR 4 '62</b>			
ADDRESS <b>Cambridge, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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FOR STATE  
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03166											
1. PLACE OF DEATH e. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural <u>Cambridge</u>				d. STREET ADDRESS <u>R.F.D. 3 (Bayly Rd.)</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Cambridge Md. Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>LeRoy John Todd</u>					4. DATE OF DEATH Month Day Year <u>March 2 19 62</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/13/35</u>		9. AGE (In years last birthday) <u>26</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Todd</u>					14. MOTHER'S MAIDEN NAME <u>Edna Hollis</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>217-30-9100</u>		17. INFORMANT Address <u>John Todd, Cambridge, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Stab wound aorta</u> (a), stating the underlying cause last. DUE TO (c) <u>982 X</u>								INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>15 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabbed by wife.</u>							
20c. TIME OF INJURY Month, Day, Year <u>11:10 a.m. 3/2/62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C.C. Cafe, Pine St. Cambridge, Dor. Md.</u>		20f. (City or town) <u>Cambridge, Dor. Md.</u>		(County) <u>Dorchester</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John Mace Jr.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>3/9/62</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cambridge, Md.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linas Rd. Cemetery</u>			22d. LOCATION (City, town, or county) <u>Dorchester, Md.</u>				
23. FUNERAL DIRECTOR <u>Herbert St. Clair</u>					ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>		

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TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 4, 5, and 6 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03139  
CERTIFICATE OF DEATH  
03129

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY in 1b <u>4 Mo's 5 Da</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>13</u> d. STREET ADDRESS <u>221 West End Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Charles James Aaron</u>		4. DATE OF DEATH <u>Mar 27 1962</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 20 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water man</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Columbus Aaron</u>				14. MOTHER'S MAIDEN NAME <u>Martha Wroten</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>220-10-6247</u>				17. INFORMANT <u>Hospital Records Cambridge Md</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>General Atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <u>Mar 22 1962</u> , to <u>Mar 27 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 26 1962</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Thomas J. Dredge</u> M.D.								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>Mar 27 62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>								22d. ADDRESS <u>Cambridge Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 29, 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Hosier Churchyard</u>				23d. LOCATION (City, town or county) (State) <u>Fishing Creek, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Dredge</u> ADDRESS <u>Cambridge, Md.</u>								REC'D BY REGISTRAR <u>Arthur S. Thomas</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					
DATE <u>APR 2 '62</u>																	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03140 CERTIFICATE OF DEATH 03130

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u> c. LENGTH OF STAY in 1b <u>2 YRS 3 MOS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTERN SHORE STATE HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u> d. STREET ADDRESS <u>PO Box 161</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGEANNA</u> <u>ARNOLD</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>8</u> <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/79</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>GEORGE W. ARNOLD</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA C MILLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>MRS RAYMOND BERRY CHESTERTOWN, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 42221 } DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> , 19 <u>59</u> , to <u>3/8</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>62</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Geo. H. Longley</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/8/62</u>
22c. PHYSICIAN'S NAME (Type) <u>GEO. H. LONGLEY</u>		22d. ADDRESS <u>RFD 2 CAMBRIDGE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/10/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Chestertown, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 9 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hwang</u>

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03141											
03131											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>8 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Colora Rural</b> d. STREET ADDRESS <b>07X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Isa Bell</b> Last <b>Atkinson</b>						4. DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/24/1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Cecil County, Maryland</b>			
13. FATHER'S NAME <b>William Ramsey Atkinson</b>				14. MOTHER'S MAIDEN NAME <b>Ella Hathaway</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>E. S. S. Hospital Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyemia</b> DUE TO (b) <b>Staphylococcus infection of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>skin of legs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/13</b> <b>1954</b> to <b>3/3/</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> <b>1962</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John F. Schneider</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>3.3.1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. John F. Schneider</b>						22d. ADDRESS <b>Easton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/6/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cem.</b>			23d. LOCATION (City, town or county) <b>Port Deposit Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leon E. M. Miller</b>						25a. REC'D BY REGISTRAR <b>Rising Sun Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>		

03181

CERTIFICATE OF DEATH

03181

Cecil

Chancellor

Married

Color

8 Years

Eastern State Hospital

Unknown

Isabel

John

75

2/1/1883

White

Female

U.S.A.

Cecil County, Maryland

Unknown

Unknown

2118 Highway

Unknown

Unknown

U.S.A. Hospital Records

None

No

23

23

23

23

23

23

Eastern, Maryland

U.S.A. Hospital

U.S.A. Hospital

Hopewell, Conn.

U.S.A. Hospital

U.S.A. Hospital

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The 4 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03142 CERTIFICATE OF DEATH 03132

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> c. LENGTH OF STAY IN b <b>7 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Md. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> d. STREET ADDRESS <b>Edlon Park, Cambridge, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank H. Banning</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1880</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>82</b>	11. IF UNDER 24 HRS. Days <b>1</b> Hours <b>19</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Chateau, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Eldridge Adams</b>		Address <b>Edlon, Park, Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>4 64 X Pulmonary Embolus</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Thrombophlebitis left extremity</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fibrosis lungs, healed tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 sec.</b> <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>008.1</b>	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cambridge</b> (County) <b>Dorchester</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> to <b>3/1</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>3/1</b> , 19 <b>62</b> and that death occurred at <b>11</b> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>W. H. Hanks, M.D.</b>		22b. DATE SIGNED <b>3/2/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS, M.D.</b>		22d. ADDRESS <b>CAMBRIDGE MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/3/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		23d. LOCATION (City, town or county) <b>East New Market, Md.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 12 '62</b>	
ADDRESS <b>Cambridge, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	



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Handwritten text, mostly illegible due to bleed-through from the reverse side. Some words like "Lithon" and "Lithon" are visible.

Handwritten text, mostly illegible due to bleed-through from the reverse side. Some words like "Lithon" and "Lithon" are visible.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03143

## CERTIFICATE OF DEATH

Reg. Dist. No. 03133

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>0</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jackson</b> Middle <b>E.</b> Last <b>Bradley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> , Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1896</b>
9. AGE (In years lost birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Mardella, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levin Bradley</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Cambridge-Maryland Hospital, Inc.</b> <b>Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mesenteric thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary decompensation</b> DUE TO (c) <b>arteriosclerotic HT. Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>under</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/9</b> , 19 <b>62</b> , to <b>3/12</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>3/12</b> , 19 <b>62</b> , and that death occurred at <b>11:45</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 RACE ST</b> DATE SIGNED <b>3/14/62</b> ACTUAL SIGNATURE <b>Alfred R. Maryaniv</b> M.D. <b>CAMBRIDGE, MD</b> PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANIV</b> <b>CAMBRIDGE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mardela</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela Springs</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co. Delmar, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 16 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			





TO HOSPITAL: This certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: This certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03144

03134

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY in 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		<u>1437-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edna</u> Middle <u>E.</u> Last <u>Bramble</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>13</u> Year <u>19 62</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-88 ?</u>	9. AGE (In years last birthday) <u>73</u> /yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Lee A. Durning</u>				14. MOTHER'S MAIDEN NAME <u>? Minnie C. Legg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>RECORDS - Eastern Shore State Hospital</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC CONGESTIVE FAILURE</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>OLD MYOCARDIAL INFARCTION</u> (c) <u>ATHEROSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 WEEKS</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>BRONCHOPNEUMONIA; PULMONARY ABSCESSSES, LEFT LOBE</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 18, 1962</u> , to <u>March 13, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3-13-1962</u> , and that death occurred at <u>3:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Geo M Dunn</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George M. Dunn</u>				22d. ADDRESS <u>Eastern Shore State Hospital, Cambridge, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chestertown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Wells Wells</u> ADDRESS <u>Chestertown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

03111

03111

M

Wm. C. Ladd

Wm. C. Ladd

Wm. C. Ladd

X

TO HOWARD ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
03145													
03136													
1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md.				c. LENGTH OF STAY IN 1b 1 Year				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md. 13					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Md. Hospital						d. STREET ADDRESS Academy St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Beckwith Cannon						4. DATE OF DEATH Month Day Year March 17, 1962							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1882		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Aireys, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gab Beckwith						14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Charles E. Cannon				Address Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Toxemia. DUE TO (c) Multiple Diverticulitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hiatus Hernia												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1/10 1962 to 3/17 1962 that (I) (we) last saw the deceased alive on 3/17 1961, and that death occurred 6:00 A.M. from the causes and on the date stated above.													
22a. SIGNATURE W. H. Hanks						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/19/62					
22c. PHYSICIAN'S NAME (Type) W. H. Hanks						22d. ADDRESS CAMBRIDGE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 19, 1962		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) Cambridge, Md. (State)							
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						ADDRESS Cambridge Md		25a. REC'D BY REGISTRAR DATE MAR 21 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

(M)

(1)

*Thyroglobulin Test*

*Thyroid Dystrophia*

*Histology*

*W. H. Jones*

*W. H. Jones*

*Cambridge, Mass.*

1  
FOR STATE  
HEALTH DEPT.

M

16

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03137									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>3yr. 1mo. 20da.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>-</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Cartwright</b>			4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 62</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-73</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>22</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>2</b> Min. <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Edward Cartwright</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>155-10-9741</b>		17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Fracture neck r. femur</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome with senile brain disease.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>12 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell in bathroom</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11 AM</b> p.m. <b>2-25-62</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Cambridge</b> (County) <b>Dor.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/9/62</b>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3-12-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mal. Board ind.</b>		22d. LOCATION (City, town, or country) <b>Baltimore ind.</b> (State)			
23. FUNERAL DIRECTOR <b>Thomas Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Carb Np</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>MAR 15 '62</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Albuquerque

Chronic brain syndrome with senile dementia.

Shipped and left in bathroom

Albuquerque

Albuquerque

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TO HOWARD COUNTY, ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03147  
CERTIFICATE OF DEATH  
03138

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cobb Island (Rural)</b> d. STREET ADDRESS <b>08X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>B.</b> Last <b>CARY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 62</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/89</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plumber - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N.P.P.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Frances D. Cary</b>					
14. MOTHER'S MAIDEN NAME <b>(Unknown) Kerrick</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <b>577-30-3567</b>		17. INFORMANT <b>Hospital records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>BRONCHIOGENIC CARCINOMA</b> (c) <b>DEHYDRATION, CACHEXIA, PNEUMONITIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DEHYDRATION, CACHEXIA, PNEUMONITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>1 YEAR +</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> , 19 <b>61</b> to <b>MAR 1</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>2:10 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Geo M Dunn</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 1, 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Geo. M. Dunn</b> M.D.		22d. ADDRESS <b>Eastern Shore State Hosp. rural Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5, 62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pearl La Plata Md.</b>			
23d. LOCATION (City, town or county) (State) <b>La Plata, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Rehark Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 9 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

03138

03147

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(1)

Director  
Chief Clerk  
3rd  
Cobb, Robert  
Cary  
7/17/68  
White  
Plumber -  
Virginia

577-10-3567 Hospital Records  
DEPARTMENT OF HEALTH, VIRGINIA

Mr. W. H. ...  
Mr. M. ...  
Mr. J. ...  
Mr. ...

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03148

Item 8, Film G-310 4/2/62.cac.

03139

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY in 1b <b>6 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b> d. STREET ADDRESS <b>413 Academy Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ESTELIA CAROLINE CORDREY</b>				4. DATE OF DEATH Month Day Year <b>March 21 19 62</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/86</b> <del>10/30/89</del> <b>6/30/86</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sussex Co., Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Kahack Cahall</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Trice Margaret Trice</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213/22/7989</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Acute myocardial infarction</b> (c) <b>Arteriosclerotic cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b> <b>17 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration, cachexia, pneumonitis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>10/19</b> , 19 <b>55</b> , to <b>3/21</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>62</b> , and that death occurred at <b>9:25AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Geo M Dunn</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>George M. Dunn</b>			22d. ADDRESS <b>E.S.S.H. spital, Cambridge, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 23, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Federalburg, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Brampton's Son, Federalburg, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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George W. Dunn

March 22, 1944

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03149  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03140  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>20 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>		d. STREET ADDRESS <u>1 303 Choptank Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge RFD # 2 Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Doris</u> <u>Dunn</u> <u>Davis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1927</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Sharptown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Dunn</u>				14. MOTHER'S MAIDEN NAME <u>Lula Eskridge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Joan Brohawn Cambridge, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial injury</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Compound fractures skull</u> (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked into path of automobile.</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:05 A.M. 3/3 19 62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 50 2 mi. West of Cambridge, Dor., Md.</u>		20f. (City or town) (County) (State) <u>Cambridge, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr. M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/6/62</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county) <u>Cambridge, Md.</u>				Address (Street, city, town, or county) <u>Cambridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>			
ADDRESS <u>Cambridge, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

03140





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03141**

03150

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. Vienna</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. #1 Vienna</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Reid's Grove</b>				d. STREET ADDRESS <b>Near Reid's Grove</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Angela</b> Middle <b>Mae</b> Last <b>Dennis</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 62</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-60</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elwood Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Sarah J. Dennis R.D. Vienna, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to smoke</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Trapped by fire in own home</b>					
20c. TIME OF INJURY Hour <b>3:10</b> <del>am</del> <b>p. m.</b> Month, Day, Year <b>3-4 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>nr. Vienna Dorchester Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3-4-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 7, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reid's Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Vienna, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Framptom and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

NOTICE: ALL BOND

NOTICE: ALL BOND

1. Name of deceased	2. Sex	3. Age	4. Race
5. Date of death	6. Time of death	7. Place of death	8. Cause of death
9. Manner of death	10. Signature of medical examiner	11. Signature of coroner	12. Signature of registrar
13. Signature of physician	14. Signature of nurse	15. Signature of undertaker	16. Signature of funeral home
17. Signature of cemetery	18. Signature of burial place	19. Signature of interment	20. Signature of record

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

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03142

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> <u>13</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>			d. STREET ADDRESS <u>306 Washington St. Camb. Md.</u>		
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Vane</u> Last <u>Dodson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>62</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Dorchester Co. U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Vane</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Horsey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lee Dodson</u> Address <u>6 Willis St. Cambridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u> DUE TO (c) <u>Fracture of skull.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of skull.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had cerebral accident, fell striking head.</u>			
20c. TIME OF INJURY Hour <u>8:45 PM</u> e.m. <u>2/19/62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Cambridge, Dor.</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED <u>Cambridge, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>March 15, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>
23. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>			ADDRESS <u>Cambridge, Md.</u>		22d. LOCATION (City, town, or country) <u>Cambridge, Md.</u>
24a. REC'D BY REGISTRAR <u>MAR 19 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

SEPCO

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TO HOSPITAL DEATH. If retained by the hospital or attending physician, the law requires that the death certificate be executed 24 hours after death. If retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03152					03143					
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>9 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u> <u>07X-2</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Emma</u> Middle <u>T.</u> Last <u>DRENNEN</u>					<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>1</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-7-86</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cecil Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
<b>13. FATHER'S NAME</b> <u>Joseph V. Thompson</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Bouchell</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT</b> <u>Hospital Record</u> Address <u>Cambridge, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>446X</u> IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>NEPHROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO (c) <u>ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>3 YEARS</u> <u>3 YEARS</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DEHYDRATION, ELECTROLYTE IMBALANCE</u>										
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>19</u> <u>MAR 1</u> , 1962 <b>that (I) (we) last saw the deceased alive on</b> <u>MAR 1</u> , 1962 <b>and that death occurred at</b> <u>4:15 A.M.</u> <b>from the causes and on the date stated above.</b>										
<b>22a. SIGNATURE</b> <u>Geo. M. L. L. L.</u> M.D.					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>MAR 1, 1962</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)					<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) (State)				
<u>Burial</u>		<u>March 5, 1962</u>		<u>Methodist</u>		<u>North East Cecil Co. Md</u>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u>					<b>ADDRESS</b> <u>North East Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 6 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

(M)

Donch-ster

Cambridge

Eastern Shore State

Emma

Female M

None

Joseph V Thompson

no

unknown

Hopital Grant

Cambridge, Md.

Anna Boushell

Coal Maryland

6-7-85

JACKSON

March 1

North East

Rural

unemployed

Uncl

Received from Mrs. Thompson  
\$100.00  
March 1, 1985

Joseph V Thompson



TO HOPE, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03153					03144				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Dorchester</b>					e. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY <b>Talbot</b>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<b>2 years +</b>					<b>Cordeba, Md</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
<b>Eastern Shore State Hospital, Cambridge</b>					<b>20X-2</b>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
<b>Roger Enoch Ellis</b>					<b>March 12 1962</b>				
5. SEX					6. COLOR OR RACE				
<b>male</b>					<b>white</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH				
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					<b>7/6/75</b>				
9. AGE (In years last birthday)					IF UNDER 1 YEAR				
<b>86</b>					Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (County & State, or foreign country)				
<b>Retired found R.A. R.A.</b>					<b>Penn. Maryland</b>				
12. CITIZEN OF WHAT COUNTRY?					<b>USA</b>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<b>Thomas L. Ellis</b>					<b>Emma Sinclair</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
<b>unk</b>					<b>unk NO</b>				
17. INFORMANT					Address				
<b>Medical Records E.S.S.H Cambridge, Md</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>									
4-9-1X DUE TO									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
<b>ARTERIOSCLEROSIS; DEHYDRATION; CACHERIA; DECUBITUS ULCER</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (this hospital) attended the deceased from <b>8/25</b> 19 <b>59</b> , to <b>3/12</b> 19 <b>62</b> that (we) last saw the deceased alive on <b>3/12</b> 19 <b>62</b> , and that death occurred at <b>5:45</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE									
<b>Geo M. Dunn</b>									
22b. DATE SIGNED <b>3/12/62</b>									
22c. PHYSICIAN'S NAME (Type) <b>George Dunn</b>									
22d. ADDRESS <b>E.S.S.H. Cambridge, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
<b>Burial</b>									
23b. DATE THEREOF <b>Mar 15, 1962</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>									
23d. LOCATION (City, town or county) (State) <b>Roslyn, Pa.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE									
<b>Maurice E. Neenan &amp; Son</b>									
ADDRESS <b>Easton, Md</b>									
25a. REC'D BY REGISTRAR									
DATE <b>MAR 15 '62</b>									
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>									



University

England

1914

Internal Medicine

2 years +

Cambridge, MA

Antony House, Cambridge

Robert

March

1915

1915

1915

male

white

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1915

1915

Thomas J. Ellis

James

Medical Records, E. S. H. Cambridge, MA

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E. S. H. Cambridge, MA

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03154

## CERTIFICATE OF DEATH

03145

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glasgow Convalescent Home</b>		d. STREET ADDRESS <b>1 413 Byrn St.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Emily Gale</b>		4. DATE OF DEATH <b>March 25, 1962 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1894</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR: Months Days Hours Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Peter Cook</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-6854</b>	
17. INFORMANT <b>Wm. C. Gale</b>		Address <b>413 Byrn St., Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>154 X Carcinomatosis</b> DUE TO (b) <b>Carcinoma Rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos 1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURED While <input type="checkbox"/> el work Not While <input type="checkbox"/> el work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-15-1962</b> to <b>3-25-1962</b> that (I) (we) last saw the deceased alive on <b>3-25-1962</b> and that death occurred at <b>7:30 A.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b> M.D.		22b. DATE SIGNED <b>3-26-62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 27, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hurlock, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Shover</b>		25a. REC'D BY REGISTRAR <b>APR 2 '62</b>	
ADDRESS <b>Cambridge, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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1945-1946, 1947-1948, 1949-1950, 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 26

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

tem 18-111 311 4-19 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03146													
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Royal Oak</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Cambridge Md. Hospital</b>						d. STREET ADDRESS <b>26 X 2</b>							
3. NAME OF DECEASED (Type or print) <b>Eric Gerald George</b>						4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/20/28</b>		9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister &amp; Teacher</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>British West Indies</b>				
13. FATHER'S NAME <b>Irenuis George</b>						14. MOTHER'S MAIDEN NAME <b>?</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>111-32-9126</b>			17. INFORMANT Address <b>Mrs Geniva George Royal Oak, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending Autopsy report</b> <b>Asphyxia</b> 753,1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Aspiration stomach contents</b> DUE TO (c) <b>Congenital malformation of brain</b>												INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>John Mace Jr.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/26/62</b>			DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>3-24-62</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Linas Rd Cem</b>				
23. FUNERAL DIRECTOR <b>Booth M West</b>						ADDRESS <b>Cambridge, Md.</b>			22d. LOCATION (City, town, or country) (State) <b>Dorchester Co md</b>				
24a. REC'D BY REGISTRAR <b>MAR 28 '62</b>						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

MEDICAL CERTIFICATION

02136

(M)

(1)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03156

03147

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> c. LENGTH OF STAY IN b <b>6 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Md. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Andrews, Md.</b> d. STREET ADDRESS <b>Andrews, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cleveland</b> Middle <b>Hayward</b> Last <b>Andrews</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21,</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 18, 1885</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b>	IF UNDER 24 HRS. Days <b>77</b> Hours <b>77</b> Min. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Andrews, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Zebedee Hayward</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Hart</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Hayward Andrews, M d.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Arteriosclerotic Nephritis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arterio sclerosis</b> (a), stating the underlying cause last. (c) <b>Hypochromic Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11/62</b> , 19 <b>62</b> , to <b>3/21/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/21/62</b> , 19 <b>62</b> , and that death occurred <b>10:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence Maryanov</b> M.D.		22b. DATE <b>3/28/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>		22d. ADDRESS <b>136 Race St. Cambridge, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 24, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		25a. REC'D BY REGISTRAR <b>DATE APR 4 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03157

Item 8 Film G309 3/23/62 iwk

03148

1. PLACE OF DEATH e. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shulock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shulock</u>	
c. LENGTH OF STAY IN 1b <u>25 yrs</u>		d. STREET ADDRESS <u>Academy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Reid Hicks</u> First Middle Last		4. DATE OF DEATH <u>3/5/1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u> <u>9/22/1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>J. Columbus Reid</u>		14. MOTHER'S MAIDEN NAME <u>Emma Howeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Ida Tillis, Shulock, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cerebral thrombosis (2)</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>10 yrs?</u> <u>25 yrs?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 1961, to <u>March</u> 1962, that (I) (we) last saw the deceased alive on <u>4 March</u> 1962, and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>1 Mr T. [unclear]</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/7/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	23d. LOCATION (City, town or county) (State) <u>East New Market, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank S. Hillyoughy, East New Market</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

VR A15 (4)  
15M 9/60

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02158

03149

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md</u> c. LENGTH OF STAY IN 1b <u>6 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenburn Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hoopersville, Md.</u> d. STREET ADDRESS <u>Hoopersville, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Martha</u> <u>Parks</u> <u>Hooper</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>March</u> <u>23,</u> <u>1962</u> Month Day Year													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 1, 1874</u>		<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Hoopersville, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Charles A. Parks</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Parks</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs Lola E. Lewis</u> Address <u>Baltimore, Md.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO <u>SENILITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>TERMINAL UREMIA</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____														<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>22a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>22b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-20-61</u> , 19 <u>19</u> , to <u>3-23-62</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>3-21-62</u> , 19 <u>19</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.																	
<b>22e. SIGNATURE</b> <u>Albert E. Bunker</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>3/24/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ALBERT E. BUNKER, M. D.</u>						<b>22d. ADDRESS</b> <u>MARYLAND AVE., CAMBRIDGE, MARYLAND</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>March 25, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Mem. Park</u>				<b>23d. LOCATION</b> (City, town or county) <u>Cambridge, Md.</u> (State)							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>LeCompte Funeral Service</u>						<b>ADDRESS</b> <u>Cambridge, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE APR 4 '62</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>			

VR A15 (4)  
15M 7/61

1944

1944

(M)

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RECEIVED

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RECEIVED



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03150

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>			c. LENGTH OF STAY IN Yr <b>61 Years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge, Md.</b>			d. STREET ADDRESS <b>302 Henry St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>302 Henry St.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Emma Sinclair Horner</b>					4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 62</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 7, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Sinclair</b>					14. MOTHER'S MAIDEN NAME <b>Martha Sinclair</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>Mrs Anna Elliott</b>					Address <b>302 Henry St. Cambridge, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C-V-R. Disease</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>									INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Mace Jr.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>3/9/62</b>				
					Address (Street, city, town, or county) <b>Cambridge, Md.</b>				
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>March 11, 1962</b>		22d. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22e. LOCATION (City, town, or country) (State) <b>Cambridge, Maryland</b>			
23. FUNERAL DIRECTOR <b>LeCompte Funeral Service</b>					24a. REC'D BY REGISTRAR <b>MAR 15 '62</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				

03120



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03160

03151

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cassons Neck</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cassons Neck RFD #3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cassons Neck</u>			d. STREET ADDRESS <u>Cassons Neck RFD #3</u>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Hubbard</u>			<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>1</u> Year <u>1962</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Cassons Neck, Dorchester Co.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Hubbard</u>			14. MOTHER'S MAIDEN NAME <u>Susie Cook</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mrs William H. Hubbard</u>			Address <u>Cassons Neck Cambridge RFD #3</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 1999X DUE TO (b) <u>Sarcoma Back</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> <u>1962</u> to <u>3/1</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> <u>1962</u> and that death occurred at <u>  </u> <u>M</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>W. H. Hanks M.D.</u>			22b. DATE SIGNED <u>3/2/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. H. Hanks M.D.</u>			22d. ADDRESS <u>Cambridge Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Speddens-Sewards Cemetery</u>	
23d. LOCATION (City, town or county) <u>James, Maryland</u>		23e. REC'D BY REGISTRAR <u>MAR 12 '62</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>					
ADDRESS <u>Cambridge, Md.</u>					

03151

CERTIFICATE OF DEATH

1918

(M)

(A)

*General Thomas*  
*James Lane*

*W. H. Hanks M.D.*  
*James Lane*  
*1/12*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03161

03152.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Taylor's Island, Md.</u>	
c. LENGTH OF STAY IN b. <u>2 Days</u>		d. STREET ADDRESS <u>Taylor's Island, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Ann Hughes</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>4</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 24, 1943</u>	<b>9. AGE</b> (In years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u>18</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Dorchester Co. Taylor's Island, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Earl W. Hughes</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hazel Meekins</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Earl Hughes</u>		<b>Address</b> <u>Taylor's Island, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VIRUS PNEUMONIA</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>SPASTIC PARAPLEGIA</u> (c) <u>SPASTIC PARAPLEGIA</u> DUE TO (e), stating the underlying cause test.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SPASTIC PARAPLEGIA</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 4, 1956</u> , <b>to</b> <u>Mar 4, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Mar 4, 1962</u> , <b>and that death occurred at</b> <u>3:30 PM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Alfred R. Maryanov</u> M.D.		<b>22b. DATE SIGNED</b> <u>3/6/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ALFRED R MARYANOV</u>		<b>22d. ADDRESS</b> <u>136 RACE ST, CAMBRIDGE, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>March 6, 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Mem. Park</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Cambridge, Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>LeCompte Funeral Service</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 12 '62</u>	
<b>ADDRESS</b> <u>Cambridge, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	

08155

0318



3



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03162											
03154											
1. PLACE OF DEATH e. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>228 Robbins St.</u>						d. STREET ADDRESS <u>228 Robbins St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Mills</u> Last <u>Jones</u>						4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Crocheron, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Mills</u>						14. MOTHER'S MAIDEN NAME <u>Sarah V. Mills</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Nons</u>		17. INFORMANT <u>Mabel V. Jones</u>				Address <u>Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>350X</u> IMMEDIATE CAUSE (a) <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Parkinson's Disease</u> (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/13/62</u> to <u>3/31</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>62</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Lawrence Maryanov</u>						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov, M.D.</u>						22d. ADDRESS <u>136 Race St Cambridge, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>				23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>						ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

03134

CERTIFICATE OF DATA

03134

(M)

(1)

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03163		03155	
1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Church Creek, Maryland</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Church Creek, Md.</b>	
c. LENGTH OF STAY IN life <b>Life</b>		d. STREET ADDRESS <b>Church Creek, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Church Creek, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Hamilton</b> Last <b>Jones</b>		4. DATE OF DEATH <b>March 11, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1870</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Merchant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Church Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Sarah L. Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Harold Delaha</b>		Address <b>Church Creek, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Acute viral infection</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 19 <b>62</b> to <b>3/11</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>62</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. H. Hanks</b>		22b. DATE SIGNED <b>3/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>		22d. ADDRESS <b>Cambridge, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 13, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		25a. REC'D BY REGISTRAR <b>MAR 19 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

03152

REPUBLICAN PARTY

03152



*Handwritten text, possibly a signature or name, appearing upside down.*

1911

*Handwritten signature or name.*

1911

REPUBLICAN PARTY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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03157

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hudson, Md.</b> c. LENGTH OF STAY in 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hudson, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hudson, Md.</b> d. STREET ADDRESS <b>Hudson, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>S.</b> Middle <b>Edward</b> Last <b>Marshall</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 62</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 7, 1875</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Buyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Hudson, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John R. Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Thomas</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr John Barnes</b> Address <b>Hudson, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aplastic Anemia</b> 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>9/6/61</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1/17</b>		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>62</b> to <b>3/3</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3/3</b> 19 <b>62</b> and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>W. H. Hanks, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <b>CAMBRIDGE, MARYLAND</b>		22c. DATE SIGNED <b>3/6/62</b>							
22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS, M.D.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 6, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Speddens-Sewards Cemetery James,</b>				23d. LOCATION (City, town or county) <b>Maryland</b> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

(M)

3/2/01

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03165 CERTIFICATE OF DEATH 03158

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 5 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 251 Race St.		d. STREET ADDRESS 251 Race St.	
3. NAME OF DECEASED (Type or print) Lula		4. DATE OF DEATH March 4, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Sussex Co., Delaware	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Massey		14. MOTHER'S MAIDEN NAME Mary E. Holt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 159-05-6926	
17. INFORMANT Miss Edna Massey, 251 Race St., Cambridge		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Arteriosclerotic cardio vascular renal disease Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis generalized (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Adenocarcinoma of cecum with operation 10-26-61			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9-61 to 3-3-62, that (I) (we) last saw the deceased alive on 3-3-62, and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Eldridge H. Wolff, M.D.		22b. DATE SIGNED 3-4-62	
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.		22d. ADDRESS 15 Locust St., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 7, 1962	
23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town or county) (State) East New Market, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shuman, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAR 9 '62	
25b. REGISTRAR'S SIGNATURE James E. Frank			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03166

Item 1c Film 6309 3/19/62 1wk

03159

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>2yrs. &amp; 2mons.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> d. STREET ADDRESS <b>107 Morris Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Alice</b> Last <b>Meredith</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 62</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1873</b>	9. AGE (In years last birthday) <b>88</b> /rs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wm. Miner</b>				14. MOTHER'S MAIDEN NAME <b>Sabina Wade</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CIRCULATORY COLLAPSE</b> DUE TO (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 HRS</b> <b>2-4 DAYS</b> <b>3 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>DEHYDRATION, CACHEXIA</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 4, 19 62</b> to <b>March 6, 19 62</b> , that (I) (we) last saw the deceased alive on <b>3-6-62</b> and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Geo M Dunn</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-6-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>George M. Dunn</b>				22d. ADDRESS <b>Eastern Shore State Hospital, Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Mar. 9, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Federalsburg Cemetery</b>	23d. LOCATION (City, town or county) <b>Federalsburg, Md.</b> (State)				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harold Williams</b> ADDRESS <b>Federalsburg, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 12 '62</b> DATE	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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you're not alone

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03167

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03160

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Petersburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>James</b> Last <b>Murray</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee American Stores Cannery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Murray</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baltimore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-2988</b>	
17. INFORMANT <b>Mrs. Naomi J. Murray, Hurlock, Md., R.F.D. #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular Accident</b> DUE TO <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO <b>Years</b> DUE TO <b>Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> <b>Instant</b> <b>Years</b> <b>Years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 12 19 60</b> to <b>March 9 19 62</b> . That (I) (we) last saw the deceased alive on <b>March 9 19 62</b> and that death occurred at <b>5P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jason F. G. Yee M.D.</b>		22b. DATE SIGNED <b>3/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>JASON F. G. YEE M.D.</b>		22d. ADDRESS <b>Hurlock, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 12, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Petersburg Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Hurlock, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

03180

CENTRAL DEPT. 14

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General Manager, Western  
Central, Houston  
Houston, Texas

WASON F. J. (M.D.)  
General Manager  
Houston, Texas



TO HO...  
death,  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03168													
CERTIFICATE OF DEATH													
03161													
1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md.				c. LENGTH OF STAY IN 1b 17 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Rural East New Market, Md.				d. STREET ADDRESS East New Market RFD Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glasgow Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) George William Powner						4. DATE OF DEATH March 13, 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Trentham, England				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Phillip Fairall Address East New Market RFD Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): Terminal Pneumonia - INTERVAL BETWEEN ONSET AND DEATH													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 8-7-53, 19 to 3-13-62 that (I) (we) last saw the deceased alive on 3-11-62, 19, and that death occurred at 2:49 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Albert E. Burkner M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-15-62				
22c. PHYSICIAN'S NAME (Type) Albert E. Burkner						22d. ADDRESS 200 Md. Ave. Cambridge - Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 15, 1962		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		23d. LOCATION (City, town or county) Cambridge, Md.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						ADDRESS Cambridge, Md.			25a. REC'D BY REGISTRAR MAR 21 '62 DATE			25b. REGISTRAR'S SIGNATURE Albert E. Burkner	

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CERTIFICATE OF DEATH

03169

Item 4 Film G310 4/4/62 jwk

03162

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i> c. LENGTH OF STAY IN b. <i>25 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>at home</i>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge 13</i> d. STREET ADDRESS <i>102 West End Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Wilby J. Pritchett</i> First Middle Last				4. DATE OF DEATH <i>March 26 1962</i> Month Day Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 30, 1869</i>	
9. AGE (In years last birthday) <i>92 yrs.</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired watchman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>+ Nightwatchman</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>							
13. FATHER'S NAME <i>John Pritchett</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Lewis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes World War I</i>				16. SOCIAL SECURITY NO. <i>213-18-4991</i>		17. INFORMANT <i>Lillian P. Newman</i> Address <i>Easton - Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Generalized arteriosclerosis</i> (b) <i>Hypertension</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Urinary obstruction due to Prostatic Hypertrophy</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>							
20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work							
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20d. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>7:10</i> to <i>3:20</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> , 19 <i>62</i> , and that death occurred at <i>6:15</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W. H. Hanks</i> M.D.				22b. DATE SIGNED <i>3/29/62</i>			
22c. PHYSICIAN'S NAME (Type) <i>W. H. HANKS, M.D.</i>				22d. ADDRESS <i>CAMBRIDGE, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Mar. 29, 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Memorial Co.</i>		23d. LOCATION (City, town or county) (State) <i>Cambridge Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thurmon E. Newman &amp; Son</i>				25a. REC'D BY REGISTRAR <i>APR 2 '62</i>			
25b. REGISTRAR'S SIGNATURE <i>Carlton S. Thomas</i>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*Staphylinus*

Library of the University of Toronto

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W. J. Brown

57. 2014. 4. 14.

CHANDLER, DEC. 17, 1942

*[Faint handwritten notes at the bottom of the page]*

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The 4 copies of the certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03170 CERTIFICATE OF DEATH 03163

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>3 yr.6mo.19da</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> d. STREET ADDRESS <b>William Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sadie (Sarah)</b> Middle <b>Shockley</b> Last <b>Shockley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-98</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>03</b>	IF UNDER 24 HRS. Hours <b>03</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank A. Hudson</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen Holloway</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>213-05-0822</b>		17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 3, 1958</b> to <b>March 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1962</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Thomas J. Dredge</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas J. Dredge</b>	
22b. DATE SIGNED <b>Mar 22 1962</b> <b>3-22-62</b>		22d. ADDRESS <b>Eastern Shore State Hosp., Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/25/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d. LOCATION (City, town or county) (State) <b>BERLIN MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Barbary</b> ADDRESS <b>Berlin Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

03180

CERTIFICATE OF DEATH

03180

George W.

William

George W.

William

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TO HOWARD COUNTY ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. The 4 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03171 CERTIFICATE OF DEATH 03164

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>2 yrs - 7mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wistover</u> d. STREET ADDRESS <u>19X-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josie</u> Middle <u>MAE</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1883</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HALLWOOD, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Trader</u>		14. MOTHER'S MAIDEN NAME <u>SARA JANE Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Patients hospital Record.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CORONARY Insufficiency</u> 420- } DUE TO (b) <u>Generalized arteriosclerosis with</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>CARDIAC Deterioration - Chronic BROWN Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs - 7mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-16-</u> 19 <u>62</u> to <u>3-17-</u> 19 <u>62</u> ; that (I) <u>(me)</u> last saw the deceased alive on <u>3-16-</u> 19 <u>62</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schneider</u> M.D.		22b. DATE SIGNED <u>3-17-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHNEIDER, M.D.</u>		22d. ADDRESS <u>EASTERN SHORE STATE HOSPITAL - CAMBRIDGE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RENOBETH BAPTIST CEM.</u>	23d. LOCATION (City, town or county) (State) <u>RENOBETH, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>CRISFIELD, MD.</u> DATE <u>MAR 20 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

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TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The 4 copies be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03173		03167	
1. PLACE OF DEATH a. COUNTY Dorchester Co b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. c. LENGTH OF STAY IN TB 80 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3 Choptank Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. 13 d. STREET ADDRESS 3 Choptank Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabella Adams Travers First Middle Last 4. DATE OF DEATH March 17, 19 62 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 6, 1863 9. AGE (In years last birthday) 98 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) Lakesville, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Levin T. Adams 14. MOTHER'S MAIDEN NAME Sally Ann Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Herbert A. Travers Address Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 50.0 PALMONARY EMBOLUS DUE TO (b) EMBOLUS FEMORAL ARTERY (LEFT) 2 days. (c) MARKED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 3/17 to 3/19, 1962, that (I) (we) last saw the deceased alive on 3/17, 1962, and that death occurred at 8 P.M. from the causes and on the date stated above.		22a. SIGNATURE W. H. Hanks M.D. 22b. PHYSICIAN'S NAME (Type) W. H. Hanks M.D. 22c. ADDRESS Cambridge Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 20, 1962 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery 23d. LOCATION (City, town or county) (State) Cambridge, Md.		25a. REC'D BY REGISTRAR MAR 21 62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service ADDRESS Cambridge, Md.			

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UNITED STATES OF AMERICA

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THE  
LIBRARY OF THE  
UNITED STATES OF AMERICA



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03175

CERTIFICATE OF DEATH

Reg. Dist. No. 03169

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> <b>13</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>138A Washington St</b>			
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>Nichols</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dor-Co-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Nichols</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Alpha Cornish-Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 10, 1961</b> , to <b>Mar 26, 1962</b> , that I last saw the deceased alive on <b>March 26, 1962</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>227 Pine St., Cambridge, Md.</b> DATE SIGNED <b>3-27-62</b>							
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		M.D. <b>227 Pine St., Cambridge, Md. 3-27-62</b>					
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter H. Holladay</i>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '62</b>	
						24b. REGISTRAR'S SIGNATURE <i>Carlton S. Pinner</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained from the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03176  
CERTIFICATE OF DEATH  
04503

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - CAMBRIDGE</u> c. LENGTH OF STAY IN 1b <u>5 YRS. 10 MO.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NORTHEAST</u> <u>07X-2</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> <u>LESLIE</u> <u>WEAVER</u> First Middle Last				4. DATE OF DEATH <u>MARCH</u> <u>29</u> <u>1962</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888 ?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK WORKS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>COUNTY UNKNOWN MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES WEAVER</u>				14. MOTHER'S MAIDEN NAME <u>JOHANNA (LAST NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-07-5516</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour e.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 15</u> <u>1962</u> to <u>MAR. 29</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>MAR. 28</u> <u>1962</u> , and that death occurred at <u>S.A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>GEO. H. LONGLEY</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>GEO. H. LONGLEY</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>RED 2 CAMBRIDGE, MD.</u>		22b. DATE SIGNED <u>MARCH 29, 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 7, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town or county) <u>Cambridge, Maryland</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Vidler (LeCompt)</u> ADDRESS <u>Cambridge Md.</u>				25a. REC'D BY REGISTRAR <u>5/4/62</u> DATE <u>APR 10 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

04203

EXHIBIT 12

0313

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any tests necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03177

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03170

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D.2</b>			
c. LENGTH OF STAY IN b. <b>15 years</b>				d. STREET ADDRESS <b>Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Godfrey Weissent</b>				4. DATE OF DEATH <b>March 28, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 24, 1901</b>	
9. AGE (In years last birthday) <b>60 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Boston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nicholas Weissent</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Bunke</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.# 1</b>				16. SOCIAL SECURITY NO. <b>077-07-1910</b>			
17. INFORMANT <b>Mrs. Rose H. Weissent, Cambridge, Md., R.D.2</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 31, 1962</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>				22d. LOCATION (City, town, or country) (State) <b>Cambridge, Md.</b>			
23. FUNERAL DIRECTOR <b>Kenneth R. Shoups</b>				24. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>			
24b. REGISTRAR'S SIGNATURE				DATE <b>APR 2 '62</b>			

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MEDICAL CERTIFICATION

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THE NEW YORK PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION



Donor's Name

Residence

Occupation

Amount

Date

Signature

Witness

Remarks

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any changes necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL CERTIFICATION

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**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03178

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03171

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rhodesdale</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Rhodesdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Cokesbury</b>		d. STREET ADDRESS <b>Cokesbury Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>D'Arcy DODGEY</b>		Middle <b>Edward Wheatley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 5, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry M. Wheatley</b>		14. MOTHER'S MAIDEN NAME <b>Verda Eskridge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Miss Essie G. Wheatley, Philadelphia, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Coronary heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cambridge, Md.</b>		20g. (County) <b>Dorchester</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/13/62</b> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 16, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Near Federalsburg, Maryland</b>		22e. (State) <b>Md.</b>		22f. (County) <b>Dorchester</b>	
23. FUNERAL DIRECTOR <b>J.J. Framptom and Son, Federalsburg, Maryland</b>		ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 16 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		24c. (City, town, or county) <b>Cambridge, Md.</b>		24d. (State) <b>Md.</b>	

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